Asthma Action Plan

Child's Name	Birthdate	Grade	School

1. Asthma Severity (check one): ◯ Mild intermediate ◯ Mild persistent ◯ Moderate persistent ◯ Severe persistent

2. Medications (at school AND at home):

A. QUICK-RELIEF medication name: 1.	MDI, oral, neb?	Dosage or No. of puffs:	
2.			
B. ROUTINE medication name (e.g. anti-inflammatory): 1.	MDI, oral, neb?	Dosage or No. of puffs:	Time of Day:
2.			
C. BEFORE PE, EXERTION medication name: 1.	MDI, oral, neb?	Dosage or No. of puffs?	
2.			

3. For student on inhaled medication (all students must go to health office for oral medications):

☐ Assist student with medication in office ☐ Remind student to take medication ☐ May carry own medication

4. Check Known Triggers: ☐ Tobacco ☐ Pesticide ☐ Animals ☐ Birds ☐ Dust ☐ Cleaners ☐ Car Exhaust ☐ Perfume ☐ Mold ☐ Cockroach ☐ Cold Air ☐ Cleaners ☐ Exercise ☐ Other:

Green Zone	Yellow Zone	Red Zone
No Symptoms	• Coughing • Wheezing • Short of breath • Chest tightness • Difficulty breathing *Action for home or school:* *Give QUICK-RELIEF medications; notify parent.*	• Coughing • Short of breath • Very fast or hard breathing • Nasal flaring • Skin retracting/sucking over neck, stomach, or ribs with breaths • Breathing so hard they cannot walk or speak • Lips or fingernail beds turn blue *Action for home or school:* *Give QUICK-RELIEF medications; notify parent.* • *If student improves to yellow zone, inform parent.* • *If student stays in red zone, begin **School Emergency Plan**.*

School Emergency Plan

IF student has:

1. No improvement 15-20 minutes AFTER initial treatment with QUICK-RELIEF medication,
2. Trouble walking or talking,
3. Chest/neck muscle retractions with breaths, hunched, or blue color;

THEN

1. Give QUICK-RELIEF medication, Call 911.
2. Repeat in 10 minutes, if help has not arrived.
3. Contact parent.

In Yellow or Red Zone? Students with symptoms who need to use QUICK-RELIEF medication may need change in routine medication. School nurse will contact parent.

Physician's Name* (print): _____ Signature: _____ Date: _____

Office address: _____ Office phone: _____

*Includes nurse practitioner or other health care provider as long as there is authority to prescribe.

Parent/Guardian Signature: _____ Date: _____ Phone: _____

Emergency phone number(s)/names of contact: _____

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